

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05152

5158

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM TURNEY DE WEESE				4. DATE OF DEATH Month Day Year MAY - 21 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY-30-1960		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GASOLINE DISTRIBUTOR.				10b. KIND OF BUSINESS OR INDUSTRY ERWIN PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES DE WEESE				14. MOTHER'S MAIDEN NAME MARGARET SPIEGEL.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. W.T. DE WEESE OAKLAND MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (c) MYOCARDIAL INFARCTION OLD						INTERVAL BETWEEN ONSET AND DEATH Immediate YEARS 6 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-18 , 19 50 , to 5-21 , 19 56 , that I last saw the deceased alive on 5-21 , 19 56 , and that death occurred at 3 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 58 2nd St. OAKLAND, MD 5-22-56							
ACTUAL SIGNATURE James H. Feaster Jr.		M.D. 58 2nd St. OAKLAND, MD 5-22-56					
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY-23-1956	22c. NAME OF CEMETERY OR CREMATORY WESTMORELAND MEMORIAL CEMETERY		22d. LOCATION (City, town, or county) (State) GREENBURG Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Boldin		ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR 5/22/56		24b. REGISTRAR'S SIGNATURE Julia H. Roeger	

CERTIFICATE OF DEATH

BUREAU V. B.

MAY 25 1956

RECEIVED

5159

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland			
c. LENGTH OF STAY IN 1b 71 yrs.				d. STREET ADDRESS 10 Mi. N W Oakland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Mi. N W Oakland, Md.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theodosia Middle Friend Last DeWitt				4. DATE OF DEATH Month May Day 30 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Zadok Friend				14. MOTHER'S MAIDEN NAME Alice Friend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Peder Baasland		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Rather than							INTERVAL BETWEEN ONSET AND DEATH 4 hrs hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 4-28-56 19 56 to 5-28 19 56 , that I last saw the deceased alive on 7-28 19 56 , and that death occurred at 8:55P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jas. H. Feaster, Jr. M.D.				ADDRESS (Street, city or town, state) 58 2nd St. Oakland, Md. DATE SIGNED 5/31/56			
PHYSICIAN'S NAME (Type) Jas. H. Feaster, Jr.				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/1956		22c. NAME OF CEMETERY OR CREMATORY Hoyes Run Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 6/2/56	
24b. REGISTRAR'S SIGNATURE Julia H. Powers							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9 JUN 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05154

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Swanton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Swanton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EDWARD</u> Last <u>DURST</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hanson Durst</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Broadwater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Pearl Durst, Swanton R.D. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. Baumgartner</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. BAUMGARTNER</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/3/56</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dry Run Rural Swanton, Garrett Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest J. Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>5/14/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 14 1956
BUREAU Y. S.

5161

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finzel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finzel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First GRACE Middle M. Last EISLER				4. DATE OF DEATH Month May Day 27 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1905	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lloyd A. Arnold				14. MOTHER'S MAIDEN NAME Susan Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Sam H. Eisler, Finzel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. myocarditis - apoplexy 442X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Cardio renal vascular disease with severe hypertension						INTERVAL BETWEEN ONSET AND DEATH 3 wks 50 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to Summer 27, 19 56 , that I last saw the deceased alive on May 27 - 19 56 , and that death occurred at 130 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dyke R. Overhart				ADDRESS (Street, city or town, state) 36 Greene St. Craswell and Md			
PHYSICIAN'S NAME (Type) Dyke R. Overhart				DATE SIGNED May 27 - 19 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-30-1956		22c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery		22d. LOCATION (City, town, or county) (State) Greenville, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 5-30-56	
				24b. REGISTRAR'S SIGNATURE Dw. Nancy N. Roe			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 4 NOV

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0515666

5162

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sang Run				c. LENGTH OF STAY IN 1b 82 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION one mile east Sang Run				d. STREET ADDRESS one mile east Sang Run			
3. NAME OF DECEASED (Type or print) First Alfred Middle Ira Last Friend				4. DATE OF DEATH Month May Day 7 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 4, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Friend				14. MOTHER'S MAIDEN NAME Rachel Friend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Address John F. Friend, Jr. Sang Run, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Heart Disease DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH First Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-1-1953 to 4-27-1956 , that I last saw the deceased alive on 4-27-1956 , and that death occurred at 11:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2nd St. Oakland, Md. DATE SIGNED 5-8-56 ACTUAL SIGNATURE James H. Feaster M.D. James H. Feaster, Jr. PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/10/1956		22c. NAME OF CEMETERY OR CREMATORY J. F. Friend home Cem.		22d. LOCATION (City, town, or county) (State) near Sang Run, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herschert C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR 5/10/56		24b. REGISTRAR'S SIGNATURE Julius A. Roman	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IRVING STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

111

BUREAU V. S.

MAY 17 1956

RECEIVED

2/10/56

5163

CERTIFICATE OF DEATH

05157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Accident				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ANNA Middle ELIZEBETH Last GEORG				4. DATE OF DEATH Month May Day 17 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1867	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Mill Run, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Frederic Neil				14. MOTHER'S MAIDEN NAME Anna Elizebeth Klotz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Raymond Georg, Daisytown, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Arteriosclerosis DUE TO (c) Diabetes						INTERVAL BETWEEN ONSET AND DEATH 3 years 10 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 16, 1956 , to May 17, 1956 that I last saw the deceased alive on May 17, 1956 , and that death occurred at 3:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) no# Maple St., Friendsville, Maryland DATE SIGNED							
ACTUAL SIGNATURE Milton Tepfer		M.D. no# Maple St., Friendsville, Maryland					
PHYSICIAN'S NAME (Type) Milton Tepfer, M.D.		Friendsville, Maryland May 19, 1956					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/20/56	22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		22d. LOCATION (City, town, or county) (State) Accident, Garrett Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ronald J. Newman				ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR MAY 21 1956	
				24b. REGISTRAR'S SIGNATURE A. H. Hedrick			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Myocarditis
chronic

3 years
10 A

May 10 20

W.D.

BUREAU V. S.

MAY 21 1956

RECEIVED

5164

CERTIFICATE OF DEATH

05159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STAR ROUTE, FROSTBURG, MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STAR ROUTE, FROSTBURG, MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BETTY Middle JEAN Last LICHTY				4. DATE OF DEATH Month MAY Day 2 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 15, 1933	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY FAMILY HOME	
11. BIRTHPLACE (State or foreign country) GRANTSVILLE, MD				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME EARL LICHTY				14. MOTHER'S MAIDEN NAME LEOSHA BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address MR EARL LICHTY, STAR ROUTE, FROSTBURG			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary abscesses DUE TO 526X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic bilateral bronchiectasis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 years 16 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 30, 1956 , to May 2, 1956 , that I last saw the deceased alive on May 1, 1956 , and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Penna DATE SIGNED 5/3/56 ACTUAL SIGNATURE A. Paige Strong M.D. Salisbury, Pa PHYSICIAN'S NAME (Type) A. PAIGE STRONG							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE, THEREOF 5/6/56		22c. NAME OF CEMETERY OR CREMATORY MT ZION		22d. LOCATION (City, town, or county) (State) STAR ROUTE, FROSTBURG MD	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Hewman ADDRESS GRANTSVILLE, MD				24a. REC'D BY REGISTRAR MAY 7 1956		24b. REGISTRAR'S SIGNATURE A. J. Hewman	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

INVEST AND STATE DEPARTMENT OF HEALTH - BIRTH - ONE 18

1956

1956

DECEASED

PLACE OF BIRTH

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

DATE OF INTERVIEW

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

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BUREAU V. S.

MAY 7 1956

RECEIVED

05160

5165

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Garrett	MARYLAND	STATE Maryland	COUNTY Garrett 166
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural Oakland	LENGTH OF STAY (in this place) 15 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Oakland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sunnyside		STREET ADDRESS (If rural give location) Sunnyside	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) James (Middle) Robert (Last) LUDWIG		(Month) (Day) (Year) May 23, 1956 19	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 20, 1872
9. AGE last birthday 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (State or foreign country) Rio, West Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phillips George		14. MOTHER'S MAIDEN NAME Ludwig Elizabeth Oats	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Lee Ludwig, Baltimore, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
450.0 IMMEDIATE CAUSE (A) Coronary Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSE(S) DUE TO (B) Arterio Sclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Age			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION June 17, 54		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 54 to 19 56 , that I last saw the deceased alive on May 13, 1956 , and that death occurred at 11:30 a.m. from the causes and on the date stated above.			
SIGNATURE J. W. Wenzel		DATE SIGNED May 24, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1956	
NAME OF CEMETERY OR CREMATORY Odd Fellow Cem.		LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
24. REC'D BY REGISTRAR DATE May 24/56		25. FUNERAL DIRECTOR'S SIGNATURE J. D. Duncan ADDRESS Thomas, W. Va.	

INSTRUCTIONS

1 M

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 306C 1-55 10M

CERTIFICATE OF DEATH

Form No. 100

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of death

5. Place of death (City, Town, Village, Hamlet, or Locality)

6. Cause of death (State immediately and briefly)

7. Duration of illness (If any)

8. Date of birth

9. Sex

10. Name of informant

11. Signature of informant

12. Name of physician (If any)

13. Signature of physician

14. Name of coroner (If any)

15. Signature of coroner

16. Name of registrar (If any)

17. Signature of registrar

BUREAU V. 2

MAY 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5166 CERTIFICATE OF DEATH

05161
 166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TERRA ALTA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE 3	
3. NAME OF DECEASED (Type or print) First Middle Last ASA RAY SISLER		4. DATE OF DEATH Month Day Year MAY 14 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1896
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) TERRA ALTA, W. VA.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ISAAC CLINTON SISLER		14. MOTHER'S MAIDEN NAME SARAH SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 236-03-9004	
17. INFORMANT Mrs. Ethel May Sisler, Terra Alta, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Effusion with Tamponade + Anoxia 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Bronchogenic Carcinoma DUE TO (c) and Atelectasis left lung + pulmonary rts.		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1956 , to May 14, 1956 , that I last saw the deceased alive on May 13, 1956 , and that death occurred at 9:42 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas. E. Smith		M.D. Terra Alta, W. Va.	
PHYSICIAN'S NAME (Type) Chas. E. Smith, M. D.		Terra Alta, West Virginia.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE P. R. Watson		ADDRESS Terra Alta, W. Va.	
24a. REC'D BY REGISTRAR 5/16/56		24b. REGISTRAR'S SIGNATURE Julia A. Rowan L.R.	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5167 CERTIFICATE OF DEATH

05162 166
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>PETERSBURG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAN D</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PETERSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>VOSSLER</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 24, 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>SAMPSON SMITH</u>			
14. MOTHER'S MAIDEN NAME <u>SUSAN SMITH CARR.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>TRACY SMITH</u> Address			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Prostateitis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 12</u> , 19 <u>56</u> , to <u>May 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 29</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>55adder St</u>			
PHYSICIAN'S NAME (Type) <u>Belknap Maryland</u>				DATE SIGNED <u>5/29/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smith Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marysville W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blaine Schaeffer</u>				ADDRESS <u>Petersburg W. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
MANNER OF DEATH		SEX	
OCCUPATION		RACE	
EDUCATION		RELIGION	
MARITAL STATUS		PREVIOUS MARRIAGES	
CAUSE OF DEATH		IMMEDIATE CAUSE	
MORBIDITY		MORTALITY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

BUREAU V. 2

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1805163

Item 9 FilmG197 5-11-56 et

5168

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crellin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>Box 74</u>			
3. NAME OF DECEASED (Type or print) First <u>Nute</u> Middle <u>Sam</u> Last <u>Stiles</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July-2, 1889</u>	
9. AGE (In years last birthday) <u>66 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1956</u>		IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1956</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired COAL MINER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>La Fayette Stiles (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Garby (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>484.1</u>			
17. INFORMANT <u>Mrs. Nute S. Stiles, Box 74, Crellin, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>10 days?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 days?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>11:03 AM</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>56</u> , to <u>5/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/30/56</u> , 19 <u>56</u> , and that death occurred at <u>11:03 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Cusby</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland Md</u> DATE SIGNED <u>5/1/56</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS F. LUSBY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-5-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ASHBY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR CRELLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emroy Boldin</u>				24a. REC'D BY REGISTRAR <u>5/4/56</u>			
ADDRESS <u>OAKLAND MD</u>				24b. REGISTRAR'S SIGNATURE <u>Julia A. Rouse</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

166

<p>1. Name of deceased (Print name and last name) _____</p>		<p>2. Sex Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p>3. Date of birth (Month, day, year) _____</p>		<p>4. Place of birth (City, State, Country) _____</p>	
<p>5. Date of death (Month, day, year) _____</p>		<p>6. Place of death (City, State, Country) _____</p>	
<p>7. Cause of death (List all causes, beginning with immediate cause) _____ _____ _____</p>		<p>8. Manner of death (Check one) Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Undetermined <input type="checkbox"/></p>	
<p>9. Signature of physician (Print name) _____</p>		<p>10. Signature of registrar (Print name) _____</p>	

BUREAU V. 2

MAY 7 1956

RECEIVED
 3/4/26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0516466

5169

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park, Md.</u>			
c. LENGTH OF STAY IN 1b <u>6 mon.</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keyser Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD RICHARD SWAUGER</u>			4. DATE OF DEATH Month Day Year <u>May 13 1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1879</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>woodsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>cutting posts</u>		11. BIRTHPLACE (State or foreign country) <u>Grantsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Issac Swauger</u>			14. MOTHER'S MAIDEN NAME <u>Virginia Layman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Charles Swauger, Grantsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Coronary sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>May 13, 1956</u> , that I last saw the deceased alive on <u>May 11, 1956</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur F. Jones</u>			ADDRESS (Street, city or town, state) <u>Oakland, Md.</u>			DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ARTHUR F. JONES</u>			<u>Oakland, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Germany Reformed</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, R.D. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Newman</u>			ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julius H. Brown</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

5170

CERTIFICATE OF DEATH

05165 / 66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) ESTELLA First FRANTZ Middle SWEENEY Last				4. DATE OF DEATH MAY - 26 1956 Month Day Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH-7-1884	
9. AGE (In years last birthday) 72 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 72 yrs.	
11. BIRTHPLACE (State or foreign country) SELBYSPOORT MD				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME EDWARD FRANTZ				14. MOTHER'S MAIDEN NAME MARY DUNHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT PERCY FRANTZ Address OAKLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Heart Disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 mos 4 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1945 to 26 May, 1952 , that I last saw the deceased alive on 26 May, 1952 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 27 May 56			
PHYSICIAN'S NAME (Type) A. E. Mance, M.D.				Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY-29-1956		22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD				24a. REC'D BY REGISTRAR 5/29/56		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED M. J. JONES		AGE 45		SEX M		RACE W		DATE OF DEATH JUN 5 1956	
PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		ZIP CODE 21201	
OCCUPATION CLERK		EDUCATION HIGH SCHOOL		MARRIAGE M		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		UNDERLYING CAUSE ARTERIOSCLEROSIS		MORBIDITY N	
DATE OF BIRTH JUN 10 1911		PLACE OF BIRTH BALTIMORE		MOTHER'S NAME J. JONES		FATHER'S NAME M. J. JONES		MARRIAGE DATE JUN 10 1935	
DATE OF MARRIAGE JUN 10 1935		PLACE OF MARRIAGE BALTIMORE		MARRIAGE LICENSE N		MARRIAGE RECORD N		MARRIAGE CERTIFICATE N	
DATE OF DEATH JUN 5 1956		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD	
OCCUPATION CLERK		EDUCATION HIGH SCHOOL		MARRIAGE M		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		UNDERLYING CAUSE ARTERIOSCLEROSIS		MORBIDITY N	

BUREAU V. S.

JUN 6 1956

RECEIVED

5171

CERTIFICATE OF DEATH

051666

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS BOX 184			
3. NAME OF DECEASED (Type or print) First HAROLD Middle O. Last TEAGARDEN				4. DATE OF DEATH Month MAY Day 25 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH-23-1887		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) OHIO	
13. FATHER'S NAME SONAS TEAGARDEN			14. MOTHER'S MAIDEN NAME EMMA WISE.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MABLE TEAGARDEN Address MT. LAKE PARK, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary heart disease (c) Arterio sclerosis							INTERVAL BETWEEN ONSET AND DEATH 12 days 1 year 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1946 , to MAY 25 , 19 56 , that I last saw the deceased alive on MAY 25 , 19 56 , and that death occurred at 4:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. France M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 26 May 56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY-28-1956		22c. NAME OF CEMETERY OR CREMATORY EGLON CEMETERY		22d. LOCATION (City, town, or county) (State) EGLON W.VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR 5/26/56	
				24b. REGISTRAR'S SIGNATURE Julia A Rowan			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAY 31 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5172

CERTIFICATE OF DEATH

05167

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Mill, Garrett Co.</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Mill, Garrett Co.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Star Route, Frostburg, Md</u>				STREET ADDRESS (If rural give location) <u>Star Route, Frostburg, Maryland</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>LEWIS</u> (Middle) <u>TURNER</u> (Last)				4. DATE OF DEATH <u>May 24, 1956</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 29, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>JOSHUA TURNER</u>				14. MOTHER'S MAIDEN NAME <u>ELMIRA GURLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Star Route, William Turner, Frostburg, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Chronic myocardial decompensation</u>						<u>5 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>						<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 2, 1956</u> , to <u>May 23, 1956</u> , that I last saw the deceased alive on <u>May 23, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. Paige Strong</u>				ADDRESS (Street, city, town, state) <u>M.D. Salisbury Panna.</u>		DATE SIGNED <u>May 24, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Ev. Ref. Cem</u>		LOCATION (City, town, or county) (State) <u>Garrett County, Maryland</u>	
24. REC'D BY REGISTRAR <u>May 26, 1956</u>		REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

5175 CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: _____ 3. AGE: _____ 4. DATE OF BIRTH: _____
 5. PLACE OF BIRTH: _____ 6. OCCUPATION: _____
 7. MARITAL STATUS: _____ 8. EDUCATION: _____
 9. RELIGION: _____ 10. RACE: _____

11. DATE OF DEATH: _____ 12. TIME OF DEATH: _____
 13. PLACE OF DEATH: _____ 14. CAUSE OF DEATH: _____
 15. MANNER OF DEATH: _____

16. SIGNATURE OF PHYSICIAN: _____
 17. SIGNATURE OF CORONER: _____
 18. SIGNATURE OF DEATH REGISTRAR: _____

19. SIGNATURE OF WITNESS: _____
 20. SIGNATURE OF DEATH REGISTRAR: _____

21. SIGNATURE OF DEATH REGISTRAR: _____
 22. SIGNATURE OF DEATH REGISTRAR: _____

23. SIGNATURE OF DEATH REGISTRAR: _____
 24. SIGNATURE OF DEATH REGISTRAR: _____

25. SIGNATURE OF DEATH REGISTRAR: _____
 26. SIGNATURE OF DEATH REGISTRAR: _____

27. SIGNATURE OF DEATH REGISTRAR: _____
 28. SIGNATURE OF DEATH REGISTRAR: _____

BUREAU V. S.

MAY 29 1950

RECEIVED

200700072001

5173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last FLAVIOUS JOSEPH TURNEY		4. DATE OF DEATH Month Day Year MAY - 25 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL-9-1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) FRIENDSVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ISAAC TURNEY		14. MOTHER'S MAIDEN NAME NANCY JANE MEYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-3616	
17. INFORMANT Address JOSEPH TURNEY MT. LAKE PARK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF NECK 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 YEAR YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-18 , 19 49 , to 5-25 , 19 56 , that I last saw the deceased alive on 5-25-56 , 19 56 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Jester Jr. M.D. 58 24 St.		DATE SIGNED 5-28-56	
PHYSICIAN'S NAME (Type) Oakland Tnd			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY-28-1956	22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY	22d. LOCATION (City, town, or county) (State) OAKLAND MD.
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR DATE 5/28/56	24b. REGISTRAR'S SIGNATURE Julia Alloway LR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9 Nnf

1956

RECEIVED

BUREAU V. 8